Local Health Jurisdictions

Key concepts and topics

- Forms of county government, special purpose districts and the relationship to local health jurisdiction governance
- Distinctions between health departments, districts, and multi-county districts, and the implications for local health jurisdiction operations
- Administrative structures of local health jurisdictions
- Key local health jurisdiction functions and programs, various arrangements of these functions inside or outside of the local health jurisdiction, and; the pros and cons of these arrangements
- Roles of local health jurisdictions and other agencies, coordinating mechanisms and funding of specific public health programs

Introduction

As part of the orientation process, new local public health officials should become familiar with the organizational structure of their local health jurisdiction (LHJ), reporting relationships and lines of communication, the governing board, what programs and services are currently provided by the agency, the organizational capacity to provide them (staffing, human resource, accounting, financial planning, and data systems) and other factors that affect agency operations. Other parts of this informal organizational review may include:

- Assessment activities and results: Previous assessment efforts, priority issues identified, important stakeholders, and externally imposed mandates.
- Mission and strategic planning efforts
- Program evaluation activities and results
- Performance according to the Baseline Assessment of Standards for Public Health in Washington State
- Financial assessment—examination of expenditures and revenues
- Community participation and involvement

Key documents and other resources that will help in this assessment of the local public health official's agency are suggested in the Learning Resource Toolkit. The following pages provide general information about LHJs across Washington State and provide context for LHJs as local government entities.

Local Government in Washington: An overview

Washington State has a strong tradition of local governance dating back to the territorial days prior to statehood in 1889. There are two "general-purpose" local governments in Washington, counties and cities (the term "cities" as used here includes towns). "General purpose" refers to government units that perform broad functions, delivering a variety of public services and providing a means for representing local citizens. In addition, there are over forty types of "limited purpose" governments,

generally referred to as special purpose districts, which deliver specific public services. In all, there are 39 counties, 281 cities and towns and some 1,400 special purpose districts. The significant number of separate and independent special purpose districts is a distinctive feature of Washington State local governance. (Municipal Resource Service Center, 2003)

Forms of County Government, Special Purpose Districts, and Implications for Local Health Jurisdictions

The state constitution authorizes the legislature to create a uniform system of government for counties. State law relating to counties is generally collected in Title 36 RCW. The uniform plan of county government provided by state law is the three-member commission form. The constitution was amended in 1948 to provide counties the option of adopting a "home rule" charter. Adoption of a home rule charter allows a county to choose a different form of government from the commission form specified by statute. (Municipal Resource Service Center, 2003) The form of county government, and the resulting differences in the composition of the governing body, has implications for the composition of the governing body for the LHJ in that county.

- **Commission Form of County Government:** The form of government provided in state law for counties is the commission form. Under the commission form, the county governing body consists of an elected board composed of three commissioners who serve as the legislative body and also perform executive functions. (Counties with populations greater than 300,000 can increase the size of the commission from three to five members). No single administrator or executive oversees a county's operations under the commission form of government.

  The board of county commissioners shares administrative and, to some extent, legislative functions with other independently elected county officials, including a clerk, treasurer, sheriff, assessor, coroner and auditor (or recorder). Other independently elected county officials and court officers include the county prosecuting attorney and the judges of the county superior court. (Municipal Resource Service Center, 2003)

- **Home Rule Charter Form of Government:** The Washington State constitution was amended in 1948 to provide the option for counties to adopt "home rule" charters to provide their own form of government. This home rule provision does not change the role and authority of counties, but it does allow counties to provide for a form of government different from the commission form prescribed by state law. By adopting a home rule charter, county voters can provide for appointed county officers (such as County Administrators or County Executives) to perform county functions previously performed by independently elected officials and can change the names and duties of the county officers prescribed by the constitution and state law. Home rule charters may not, however, change the elected status and duties of the county prosecuting attorney or superior and district court judges, or the jurisdiction of the courts. The duties of the board of county commissioners and other elected officers may also be modified by charter. The board of commissioners and other elected officers may be entirely replaced, subject to certain restrictions. (Municipal Resource Service Center, 2003)

  Five counties have elected to adopt home rule charters:
  1) Clallam (1979)
  2) King (1969)
  3) Pierce (1981)
  4) Snohomish (1980) and
  5) Whatcom (1979).

- **Special Purpose Districts in Washington:** In Washington, special purpose districts are limited purpose local governments separate from a city, town, or county government. They provide an array of services and facilities that are not otherwise available from city or county governments. Special purpose districts are generally created through the county legislative authority to meet a specific need of the local community. They are political subdivisions of the state and come into existence, acquire legal rights and duties, and are dissolved in accordance with statutory procedures. Enabling legislation sets forth the purpose of the district, procedures for formation, powers, functions and duties, composition of the governing body, methods of finance, and other provisions. The chart below identifies some of the special purpose districts related to public health, along with the enabling legislation and type of governing body. (Municipal Resource Service Center, 2004)

Type of Special Purpose District	Enabling Legislation	Governing Body
Emergency Medical Service	36.32.480 RCW	Designated by statute
Emergency Service Communication	RCW 82.14B.070-.100	Designated by statute
Health	**Chapter 70.46 RCW**	**Designated by statute**
Mosquito Control	Chapter 17.28 RCW	Designated by statute
Public Hospital	Chapter 70.44 RCW	Designated by statute
Rural Public Hospital (defined)	RCW 70.44.450 - .460	Designated by statute
Solid Waste Disposal	RCW 36.58.100	No separate governing board

Local Health Jurisdictions and Local Boards of Health

LHJs are entities of local government, either as departments within "general purpose" local governments, or as special purpose districts. According to state law every county must either form a local health department or district, or be a part of a health department with other counties (RCW 70.05).

Enabling legislation for LHJs is found in the Revised Code of Washington (RCW), Title 70. Title 70 RCW places primary responsibility for public health activities with local governments, giving local boards of health broad responsibilities for protecting the public health through program design and delivery, rule making authority, enforcement and control powers, reporting requirements, and establishing fee schedules for licenses or permits or other services. Regardless of the structure of the LHJ, boards of health, by law, are composed primarily of elected officials. Recent legislation has allowed community citizens in some counties to serve as board members, in addition to elected officials, so long as persons other than the elected officials "do not constitute a majority" (RCW 70.46.020, RCW 70.46.030, RCW 70.46.035). This structure is often referred to as an "**expanded board of health".**

Health Departments and Health Districts – Distinctions and Implications

The primary difference between health departments and health districts is in governance. The governing body, or local board of health, is structured differently under state law for health departments and health districts. Programs and services may also vary significantly. However, this difference is more likely a function of size, funding, local priorities and other factors. For example, in some small and medium size counties, LHJs are organized to include both health and a variety of human services programs.

- **Health Departments** are departments within general-purpose local government. As such, their governing board, or local board of health is comprised primarily of the County Commissioners of that county. Approximately two-thirds of LHJs are health departments. These include both single county departments and the two combined city-county departments in the State. (RCW 70.08 states that cities with a population of over 100,000 may combine with their county to form a health department.)

- The composition of the Board of Health for **health departments** is defined in statute for each type of county government: commission or home rule charter.
  - In **counties under the commission form of government**, the Board of County Commissioners constitutes the local board of health for single county health departments (RCW 70.05.030).
  - In **counties with a home rule charter**, the county legislative authority establishes a local board of health and may prescribe the membership and selection process for the board for single county health departments (RCW 70.05.035)

- **Health Districts** are special purpose districts created under Chapter 70.46 RCW. As special purpose districts, their governing boards include members outside the commissioners of a single county. Approximately one-third of LHJs are health districts that operate as political subdivisions separate from other offices of county government. A health district may be formed within a single country, or with multiple counties.
  - **Multi-County Health Districts**: In the late 1960s and early 1970s local governments and the Health Services Division of DSHS began efforts to combine less populous health departments into multi-county health districts. The purpose of multi-county health districts was to reduce administrative costs, increase technical expertise, and provide a broader base of services to the district's residents. This resulted in the formation of several multi-county health districts, with counties of smaller populations often combining with an adjacent, more populous county to form a district. That trend has been reversed over the past few years, with several multi-county districts separating to create individual county health departments, some serving small populations with a small local funding base. Currently, there are three multi-county health districts – the Northeast Tri-County that includes Pend Oreille, Stevens, and Ferry counties, the Benton-Franklin Health District, and the Chelan-Douglas Health District.

- The governing body for health **districts,** as special purpose districts created under state law, is also defined in statute.
  - For **single county health districts** the county legislative authority specifies board membership, and may appoint elected officials from cities and towns to serve on the board (RCW 70.46.031).
  - For **multi-county health districts**, state law stipulates that the local board membership must represent the counties that comprise the district. There must be two county commissioners of each county within the district. The boards of county commissioners from each county may, by resolution or ordinance, provide for the membership of elected officials cities and towns within the district (RCW 70.46.020).

Local Health Jurisdiction Administrative Structures and Functions

Local Health Officer
All health departments and health districts are required by law to have a local health officer. By state law, a local Health Officer must be a licensed physician with specific education and training in public health and with certain fixed responsibilities.

- Qualifications of the Local Health Officer are defined in RCW 70.05.051 – 055.
- The powers and duties of the local Health Officer are defined in RCW 70.05.070. The Health Officer is given the power to enforce the public health statutes of the state, rules of the State Board of Health and the Secretary of Health, and all local health rules, regulations and ordinances within his or her jurisdiction. The Health Officer also has the responsibility to "inform the public as to the causes, nature and prevention of disease and disability, and the preservation, promotion and improvement of health."

Specific health officer roles and responsibilities vary from LHJ to LHJ and may also vary over time; however, common themes in their activities do exist:

- Infectious diseases and environmental health are primary areas of responsibility for all health officers, each with a number of regulatory responsibilities.
- Health officers are frequently required to interpret and communicate health data and information in a variety of settings and help identify priorities and emerging trends. As public health leaders in their communities, they often mobilize and educate the community and help them decide on actions to address problems.
- Health officers typically play a critical role in health jurisdiction activities through their relationships with key entities, particularly the local boards of health, city council, the medical community, the media and the public.

Administrative Officer or Director
The local board of health may also hire an Administrator or Director to direct and oversee the day-to-day operations of the department or district.

- The responsibilities of the administrative officer for local health departments are defined in RCW 70.05.045.
- The powers, duties and qualifications of the Director for combined City-County health departments are defined RCW 70.08.040 – 060.

In many LHJs, the Health Officer is a part-time position and the Administrator or Director is a full-time position.

Administrative Structures
In 1998, the Institute of Medicine report, *The Future of Public Health,* described the core functions of public health as assessment, policy development, and assurance. Most LHJs are not organized along these lines, although some have attempted to do so. Traditionally LHJs in Washington have been organized as follows:

- Agency administration, which usually includes the Health Officer and Administrator or Director, the functions of the Local Registrar (for recording vital events of birth and death in the jurisdiction) and most of the administrative support functions of the agency
- At least two operational sections or divisions,
    - Personal Health and/or Community Health and
    - Environmental Health

While this administrative structure exists in many LHJs, it varies significantly from jurisdiction to jurisdiction. Some have separate community health assessment divisions, and/or health education or health promotion sections that cross these traditional boundaries. In some jurisdictions, services for communicable disease control are in a division separate from the Personal Health or Community Health Services Division. In others, the clinical or epidemiological functions related to communicable disease control are in separate divisions. In addition, the level of clinical services provided by LHJs can range from complete primary care to virtually none at all.

Assurance of service provision:
One of the three core functions of public health is to assure that needed services are provided to the public. Traditionally this resulted in LHJs delivering the needed services directly to the community through programs such as those described in the following pages. Over the last decade, due to legislative changes, funding reductions, changes in the public health field and other factors, LHJs have increasingly questioned whether to provide services directly or assure that others provide needed services in the community. The adoption of the Health Services Act of 1993 (Health Care Reform) increased the transition of some clinical services related to communicable disease control (TB, STD, immunizations) and maternal-child health (well-child clinics) out of LHJs to the private sector. The 1995 Legislature repealed Health Care Reform without providing adequate alternative funding. This left many LHJs wondering how to evaluate the pros and cons of transitioning clinical services to the private sector.

In deciding whether or not to transition services to the private sector or other agencies, there are general questions and issues that should be considered:

1) What is the government public health responsibility for the service?
2) What stakeholders need to be considered in the decision-making process?
3) Is the service available elsewhere in the community and if so, how much access is there to the service?
4) What is the quality of the service that is available in the community?
5) Will the cost of the service and the ability to pay, or the lack thereof, be a constraint to getting the needed service?
6) For clinical services and some personal health services:
    - Is continuity of care an issue to be considered?
    - What other client-related issues should be considered; for example, are there clients with transportation constraints who need immunizations, WIC services, family planning services, and maternity support services?
    - Is confidentiality an issue to be considered?
7) What are the financial implications of transitioning the service?
    - Will administrative and overhead costs be reduced, or simply redistributed to remaining programs and services?
    - Are there funding streams to support other essential public health services in the absence of the Medicaid, state, and other funding for providing the direct service?

Decision Models
Five decision models have been used to assist LHJ leadership in applying specific criteria for making decisions regarding program priorities and transitioning services to the community.

1) *Mission/Risk Driven Priorities Model*: The LHJ may rethink their core mission and business, and focus on the high-risk populations and activities targeted at high-risk situations for environmental health. In this model the ability of someone else in the community provide the service should be considered. The LHJ can also support development of these services in the community.

2) *Funding and Mandate Driven Model*: Health department programs are reviewed and ranked (from highest to lowest priority to maintain) according to the following criteria. Cuts are focused on programs that duplicate effort of others in the community and ranked lowest priority.
   Criteria:
   - Funded and mandated (highest priority)
   - Not funded, mandated
   - Funded, not mandated
   - Not funded, not mandated (lowest priority)

3) *Program Driven Model:* Health department programs are reviewed and evaluated according to the following questions:
   - Is there a need for a government role?
   - Degree of primary prevention?
   - Degree of direct public benefit?
   - How effective is the program?
   - Benefit related to cost?
   - Severity of condition or health threat prevented?
   - Degree of political support*?*

4) *Performance Standards Driven Model: T*he Public Health Performance Standards are used as a guide and programs are evaluated according to the following criteria:
   - *Does it address a public health problem?*
   - *Is it consistent with LHJ responsibility and authority?*
   - *Are there effective interventions?*
   - *What is the budget impact?*

5) *Zero Based Budgeting Model:* The LHJ uses zero based budgeting to fund future programs, thereby eliminating programs that are not funded, regardless of the risk levels or unfunded needs of the community.

LHJ Programs and Services

Given the different local priorities, demographics, and resources services and programs provided by LHJs across the state vary from one LHJ to another. Programs that may be available in a particular local health jurisdiction are described in the pages that follow.

Public Health Emergency Preparedness and Response

http://www.doh.wa.gov/phepr/default.htm

The role of public health in an emergency, including a bioterrorism event, is an extension of the general mission of public health: to promote physical and mental health and prevent disease, injury, and disability (Public Health Functions Steering Committee*, 1994).* Although public health has always been concerned with emergency planning, the emergence of new public health threats -

including bioterrorism – requires that public health agencies be prepared to respond quickly to a wide variety of threats on a potentially large scale. Since 9/11 there has been a renewed national effort to strengthen the public health system. As part of this effort, DOH was awarded federal funding for improving public health preparedness for bioterrorism and other public health emergencies in Washington State. Funds are earmarked to "focus areas", including planning and readiness; surveillance and epidemiology, biological and chemical laboratory capacity; information technology/Health Alert Network; risk communications, education and training, and hospital preparedness. DOH distributes the major portion of grant money to local partners, including LHJs.

Every LHJ was provided funds through the DOH consolidated contract to undertake work related to the Public Health Emergency Preparedness and Response Program (PHEPR). Each LHJ is required to develop a written bioterrorism/emergency response plan, consistent with the resources and needs established for their county or counties. These plans are expected to become part of or be consistent with the local comprehensive emergency management plan. LHJs are also expected to conduct tabletop or other types of practice exercises of the emergency response plans, coordinate with local emergency management agencies and with the regional PHEPR efforts.

Local efforts are supported through nine public health emergency preparedness and response regions, each with a designated regional lead agency. LHJs designated as LHJ regional leads are Benton-Franklin, Kitsap, Chelan-Douglas, King, Pierce, Snohomish, Clark, Spokane and Thurston. LHJ Regional Leads receive additional funding to increase capacity across all LHJs in their region. They are responsible for:

- Providing assistance to each LHJ in the designated regional area in assessment and planning;
- Facilitating processes to establish regional priorities;
- Developing mutual aid agreements within and between regions;
- Improving epidemiology and surveillance capacity for public health preparedness and response to terrorism;
- Improving capacity for delivering education and training to manage public health emergencies and response to terrorism;

Community Health Assessment

Assessment is one of the three core public health functions, and is addressed within the ten essential public health services as follows:

- Monitor health status to identify community health problems
- Diagnose and investigate health problems and health hazards in the community
- Inform, educate and empower people about health issues

The *Standards for Public Health in Washington State* also underscore the importance of assessment in public health. One of the five key areas of the standards is devoted to "Understanding Health Issues, Standards for Community Health Assessment"
(http://www.doh.wa.gov/standards/default.htm#UnderstandingHealthIssues)

DOH and LHJs have been working together to improve community health assessment capability. As part of the implementation of the Public Health Improvement Plan in the mid-1990's, each LHJ completed a mandated community health assessment that involved community members and was used to set local priorities for public health improvement. LHJs were supported by DOH in fulfilling their assessment requirement through 1) the creation of an assessment liaison position within DOH) 2) the development of networks for peer exchange, learning and coordination across LHJs and between local health and DOH; 3) the provision of training and technical assistance in assessment;

4) the establishment of the Vista Partnership (described in the Learning Resource Toolkit); and 5) the development of guidelines for analysis of assessment data.

In 2002, the U.S. Centers for Disease Control and Prevention awarded funding to DOH to improve the quality and effectiveness of community health assessment practice among LHJs across the state. To implement the grant, LHJs and DOH formed the Assessment in Action (AIA) partnership. A steering committee, comprised of LHJ and DOH representatives provides leadership for implementation of the partnership, and an advisory committee made up of a broad-based group of individuals provides input. More information about the Assessment in Action Partnership is available at http://www.doh.wa.gov/EHSPHL/AIA/default.HTM. Another valuable assessment resource is AssessNow, a web-based resource that provides tools and resources to improve community health assessment practice (http://www.assessnow.info/)

According to the *Community Health Assessment in Action Report,* a 2003 report on community health assessment practice within the state's LHJs,

- Every LHJ performs some assessment activities; not every LHJ (nor everyone at the LHJ) thinks of these activities as community health assessment
- Most LHJs see the value of community health assessment, even if they believe they lack the capacity to sustain effective assessment practice
- For LHJs that do not consider assessment very important, the main reason cited is a lack of discretionary funding
- Nearly all LHJs have lost funding and assessment capacity since the mid-1990s

In LHJs across the state, community health assessment is implemented in a way that is tailored to each community and determined by factors such as resources (funding, staff capacity, DOH support, technology and data, and community partners), priority placed upon assessment, organizational capacity and community participation. Most LHJs use some of their Local Capacity Development funds to support assessment. Other funding sources include grants, contracts, county general funds, and local funds. A few LHJs do not fund assessment activities. (*Assessment in Action Report*, 2003)

Infectious/Communicable Disease Prevention and Control

Protecting people from disease is one of the five key areas of the *Standards for Public Health in Washington State.* The Standards address methods to assure Washington State has effective systems and competent staff for surveillance, disease investigation and public information in disease outbreaks (http://www.doh.wa.gov/standards/default.htm#ProtectingPeoplefromDisease). The strength and performance of these systems are also a focus of emergency preparedness efforts for both state and local public health departments, due to the threat of bioterrorism.

Preventing and reducing the spread of infectious disease is an essential responsibility of public health (Chapter 246-100 WAC). State and local health departments collaborate to accomplish this function. Community-wide disease surveillance, tracking and investigation are conducted by most LHJs, with epidemiological and laboratory support available through DOH. LHJs work closely with medical providers to assure prompt treatment and prevent further spread of disease. Many LHJs use a variety of strategies for communicating and working with the provider community, such as newsletters, designated liaisons and 24 hour telephone and fax lines for disease reporting.

Notifiable Disease Reporting (http://www.doh.wa.gov/Notify/)

Washington State law (RCW 43.20.050) requires reporting selected diseases and conditions to local health authorities. Under WAC 246-101 health care providers are responsible for reporting over 60 communicable diseases or syndromes to LHJs, and laboratories must report over 25 communicable diseases Suspected or confirmed cases of each notifiable condition should be reported within specific timeframes – immediately, within 3 work days, or within one month

As with other areas of public health, there is no dedicated state funding for the infrastructure and activities LHJs carry out related to general communicable/infectious disease prevention and control (surveillance, epidemiology, investigations, laboratory testing, etc.) However, some state and federal funds are available and distributed to LHJs for activities related to some specific diseases (HIV/AIDS, tuberculosis, and sexually transmitted diseases), and approaches to preventing and controlling these diseases are often organized into separate programs as outlined below.

- **HIV / AIDS**
  Individuals engaging in high-risk behaviors for contracting HIV are an important focus of most LHJs HIV/AIDS programs. Most LHJs offer some combination of: HIV education, outreach, testing, case management and referral services, partner notification and training for health providers as strategies for prevention and care of HIV/AIDS.

  HIV prevention services are funded primarily through a system known as the Regional AIDS Service Networks (AIDSNETs). The LHJ in the most populous county in each region administers and coordinates services in the AIDSNETs. These LHJs serve as the regional link to federal and state AIDS funding for the counties in their region. The Regional AIDS agency, or AIDSNET, allocates funding for HIV/AIDS prevention and care to local public health agencies and a variety of community- based organizations and oversees regional implementation of the Washington State AIDS Omnibus Law (1988). Meetings involving LHJs and others within the AIDSNET are held in most regions. (http://www.doh.wa.gov/cfh/HIV_AIDS/Prev_Edu/aidsnets.htm)

- **Tuberculosis (TB)** (http://www.doh.wa.gov/cfh/TB/default.htm)
  Control of TB is identified as a public health mandate under Chapter 70.28 RCW. TB prevention and control priorities for most LHJs include assuring:
  - Outreach and/or access to TB screening
  - Identification of groups at high risk for TB
  - Diagnosis and treatment of disease
  - Monitoring adherence to and completion of treatment;
  - Outbreak investigation
  - Community partnerships in the efforts against tuberculosis

  Most LHJs provide TB tests for individuals at high-risk for tuberculosis. Diagnosis and treatment of TB may be provided directly through the LHJ or through the private medical community. DOH provides:
  - Technical assistance and health education to LHJs, health professionals, and communities;
  - Medical consultation;
  - Disease and laboratory surveillance; and
  - Assistance with contact investigations

- **Sexually Transmitted Diseases (STD)**
  LHJ responsibilities and authority for control and treatment of sexually transmitted diseases are defined in Chapter 70.24 RCW. Most LHJs offer some combination of
  - Information and education

- Confidential diagnosis and treatment
- Partner notification, follow-up and referral services for preventing and controlling the spread of sexually transmitted diseases.

Many LHJs no longer provide diagnostic and treatment services for STD and must work closely with Community and Migrant Health Centers, Family Planning agencies and private providers to assure diagnosis and treatment, reporting, and partner notification services to prevent and control the spread of STDs within their jurisdiction.

DOH provides statewide data collection, analysis and dissemination, laboratory screening, educational materials, assistance with contact investigations in some cases, and technical assistance and training (http://www.doh.wa.gov/cfh/STD/).

- **Immunizations**

LHJs provide a range of activities to assure immunization of the population. Most LHJs offer some combination of:

- Promoting the immunization of adult high-risk/vulnerable populations by providing or promoting influenza and pneumococcal vaccination;
- Conducting activities to prevent perinatal hepatitis B infection
- Working to improve access to immunization services;
- Providing immunization clinics
- Working to improve immunization practices and service provision within the community;
- Distributing vaccines to local providers and performing vaccine accountability activities and requirements (specified through the DOH consolidated contract)
- Working with schools, day care and child care facilities to meet their legal requirements related to immunizations

LHJs use a combination of state, federal pass-through and local revenue sources to fund immunization program activities. All LHJs receive some funding for immunizations through the DOH consolidated contract. Those that provide immunization clinics usually collect fees, Medicaid and insurance reimbursement for services. Some agencies utilize local capacity development funds (LCDF) to help cover immunization program costs, and many earmark a portion of their local government contributions to this program.

At the state level, the DOH immunization program (http://www.doh.wa.gov/cfh/immunize/)

- Works with LHJs and other community partners to prevent disease and improve immunization coverage.
- Provides funding and technical assistance to local communities, including LHJs to increase immunization levels.
- Distributes publicly funded vaccines to LHJs, which in turn, distribute them to local health care providers for use by patients at no cost.
- Works with the DOH Office of Communicable Diseases and Epidemiology to provide technical assistance for outbreaks.
- Assesses immunization levels by reviewing school and licensed childcare facility records and by conducting other special assessment projects.

Maternal-Child Health Services (MCH)

These services target a specific population: women, infants, children and adolescents (including pregnant and parenting teens). A variety of services are provided to this population by LHJs, using a combination of state, federal and local funding. (All LHJs receive an allocation for MCH services from DOH through the consolidated contract.) DOH and LHJs work together through a regional MCH structure, with meetings of DOH and LHJ staff occurring on a regular basis in each region. Broad objectives of MCH programs include:

- Improving birth outcomes by increasing the number of women receiving early and adequate prenatal care;
- Improving health status of children by promoting breastfeeding, childhood immunizations and well-child checkups;
- Improving health status of communities through:
  - Awareness/education campaigns addressing specific health problems in communities, such as teen pregnancy, low immunization rates, lead poisoning, high infant mortality, high dental caries rates, and high childhood accidental or unintentional injury rates; and
  - Targeting evidence-based interventions to specific populations.

LHJs use a variety of strategies that cut across specific programs to accomplish these objectives, such as:

- Developing policies and plans that support individual and community efforts to improve maternal-child health;
- Working with the community to improve access to care;
- Developing community partnerships and coalitions focused on specific health issues;
- Collecting and analyzing maternal and child health data;
- Identifying populations at risk;
- Providing outreach and linkage to services;
- Providing health education and health promotion services; and
- Targeted interventions to specific populations

These services may be provided at the individual, family, and community levels in various settings (homes, clinic, neighborhood, schools, etc. A description of some of the maternal-child health programs provided by LHJs follows.

- **Children with Special Health Care Needs**

  Children with special health care needs have, or are at risk for ongoing physical, cognitive or mental health problems. Most LHJs provide some combination of services for these children and their families, including early identification and tracking, screening and referral, nutrition assessment, health education, information and linkage to community resources, and help with transition from pediatric to adult care systems. Limited financial assistance may be available for specialized medical care not covered by insurance or medical coupons. This program is funded through multiple sources, including DOH, Medicaid, DSHS , and local funds. (All LHJs receive funding through the consolidated contract for services for children with special health care needs.),

  At the state level, DOH provides resources and funding for services at the state, regional and local levels to link, coordinate, and pay for care for children with special health and/or developmental needs. A primary focus is working to develop coordinated systems of care for these infants, children and their families. DOH also supports a regional and statewide communication network of agencies working with this population. The CSHCN Coordinator for

each LHJ is encouraged to participate in the regional meetings. (http://www.doh.wa.gov/cfh/mch/CSHCNhome2.htm)

Other programs targeted to this population and provided by some LHJs include:

- Infant Toddler Network – Families of young children (birth to age 3) with developmental delays or a condition that may result in a developmental delay are assisted and supported by family resources coordinators. A child may also be eligible if there is a vision and/or hearing loss. Families are assisted with access to early intervention services, financial and other community resources. The Infant Toddler Network is funded by DSHS through the Individuals with Disabilities Education Act (IDEA-Part C).
- WorkFirst Initiative – Public health nurses assess the special needs of children referred by state WorkFirst social workers, to determine the impact of the child's needs on the parent's ability to participate in the WorkFirst program. A plan is developed to ensure the family is engaged in activities leading to eventual economic self-sufficiency, while nurses work to ensure the necessary support is received to address the child's needs. Medicaid funds this program.

- **Healthy Child Care**
  The purpose of this program is to promote health and safety, and prevent illness and injury in childcare environments. Through this program, many LHJs offer health promotion and disease prevention services for licensed child care providers. LHJ staff, usually a public health nurse, provide consultation, education, and resource referral for child care providers. In some LHJs, an interdisciplinary team of health professionals, including public health nurses, environmental health specialists, nutritionists and health educators work with child care providers in an effort to create and maintain environments for children that are healthy, safe, and nurturing. At the state level, Healthy Child Care Washington (HCCW) is a partnership of the DOH Division of Maternal & Child Health, Washington State Child-Care Resource & Referral Network, the DSHS Division of Child Care and Early Learning, and the University of Washington. DOH administers HCCW, and coordinates services with LHJs (http://www.doh.wa.gov/cfh/mch/cahcp/child_care.htm)

- **First Steps** (http://fortress.wa.gov/dshs/maa/firststeps/)
  First Steps is a program that helps low-income pregnant women get the health and social services they may need. It is administered through the DSHS and DOH. LHJs receive fee-for service Medicaid reimbursement through DSHS and often combine this with local funds or MCH funds received through the consolidated contract to cover program costs. First Steps encompasses two sets of services: Maternity Support Services and Infant Case Management. Both services are often provided by LHJs. Other community-based organizations and providers may also provide First Steps services within the jurisdiction, and in many counties there are multiple providers.

  Maternity Support Services (MSS) include an assessment, education, intervention and counseling. A team of community health specialists provides the services. The team includes nurses, nutritionists, and behavioral health workers and, in some agencies, community health workers. The intent is to provide MSS as soon as possible to promote positive birth and parenting outcomes. Sometimes there are family situations that place infants at higher risk of having problems. Infant Case Management services work with these families to help them learn to use community resources for help with housing, education, employment assistance and other services they may need, such as drug and alcohol counseling.

- **Early Intervention Program (EIP*)*** – This program is administered through DSHS and contracted to LHJs. At the local level, children and families at risk for child neglect are identified by Child Protective Services (CPS) and referred to the LHJ for services. In most LHJs, public health nurses make home visits to these families to help them learn about child development and parenting; connect them to needed community resources, identify health and/or developmental issues and provide specific health interventions according to need.

- **Passport Progra*m*** – (http://www1.dshs.wa.gov/basicneeds/cgs2ppfc.html) LHJs and the DSHS Children's Administration collaborate to administer this program, which is contracted to LHJs. The purpose of the program is to help children placed in foster homes receive the health care they need. The Division of Child and Family Services (DCFS) refers children placed in foster homes for longer than 90 days to the Passport Program. At the local level, public health nurses located in DSHS Children's Administration offices gather medical histories of these children to create a "passport" for each child. The medical history of each child is reviewed, analyzed and tracked. The "passport" is assessed every six months and appropriate health care is recommended to the foster parent and caseworker.

- **Oral Health Program**
  Prevention of early childhood tooth decay through improved access to dental services is the focus of many oral health programs in LHJs. Some LHJs work to develop or participate in oral health coalitions in their communities. These coalitions are usually a diverse group of individual and organizations that work together on issues and activities to improve the oral health of the community. Many LHJ programs combine state, federal and local funds for oral health programs. DOH provides funds to every LHJ for oral health through the consolidated contract. (http://www.doh.wa.gov/cfh/mch/cahcp/oral_health.htm)

  ABCD Program (http://www.abcd-dental.org/)
  Another strategy for improving access to dental care for children is the ABCD program ABCD focuses on preventive and restorative dental care for Medicaid-eligible children from birth to age six, with emphasis on enrollment by age one. It is based upon the premise that starting dental visits early will yield positive behaviors by both parents and children, thereby helping to control the caries process and reduce the need for costly future restorative work. The ABCD Program is a cooperative venture of several government and private entities, DSHS, the Washington State Dental Society, the Washington Dental Service Foundation, and the University of Washington School of Dentistry. LHJs often play an important role in facilitating the development of an ABCD program in their community.

- **Women, Infants and Children (WIC*)*** http://www.doh.wa.gov/cfh/WIC/default.htm)
  WIC is a preventive health program administered at the state level through DOH and designed to influence positive, lifetime nutrition and health behaviors. At the local level, WIC services may be provided by LHJs and/or other community-based agencies. Many counties have more than one WIC provider. WIC provides pregnant and breast feeding women and children from birth up to age five with nutrition education, breast feeding support, health referrals, and checks to purchase nutritious food in community grocery stores. Nearly half of all babies born in Washington benefit from WIC. To be eligible families meet the WIC income guidelines. Families receiving TANF, Food Stamps, Medicaid or Healthy Options are automatically income eligible. WIC also provides nutrition screening to help determine eligibility.

Family Planning and Reproductive Health Services
(http://www.doh.wa.gov/cfh/FPRH/default.htm)

Family Planning and Reproductive Health Services (FPRH) works to reduce the health and social impacts of unintended pregnancy by helping men and women choose the timing and spacing of their pregnancies. The target populations for FPRH services are women and men in need of subsidized services without access to other providers, and adolescents, regardless of income. Eight LHJs provide family planning clinical services: Jefferson County Health and Human Services Department, Grays Harbor Health and Human Services Department, Kitsap County Health Department, Northeast Tri-County Health District, Clark County Health Department, Klickitat County Health Department, and Thurston County Health and Human Services. Those LHJs that do not provide clinical FPRH services directly work closely with the Family Planning or Planned Parenthood agency in the community.

Other Wellness, Prevention and Risk-Reduction Programs

These programs work to promote healthy lifestyles and to prevent injury and chronic disease. They concentrate on early detection and preventing the real causes of most chronic diseases and injuries; tobacco use, lack of physical activity, poor diet, and not using seatbelts and helmets, or not taking measures to prevent injury and violence.

- **Nutrition and Physical Activity –**
  Steps to a HealthierUS is a national initiative aimed at reducing the burden of chronic disease in the United States. In particular, Steps to a HealthierUS improves health by reducing diabetes, obesity, asthma, and complications of these conditions in funded communities across the country. In Washington State, Steps to a HealthierWA helps to enhance and integrate programs that reduce chronic diseases in neighborhoods, schools, work-sites and healthcare settings. Currently, this program is funded in 6 counties and the Colville Reservation. More information about Steps to a Healthier WA is available at http://www.doh.wa.gov/cfh/steps/default.htm

- **Tobacco Prevention and Control Program** In most LHJs, this is a comprehensive public health initiative working with schools, businesses and community partners to prevent and control tobacco use in order to reduce the negative health impacts. Various strategies are used to reduce youth tobacco access; prevent tobacco use by youths; help individuals who want to quit tobacco use; and reduce exposure to secondhand smoke. LHJs work with DOH's Tobacco Prevention and Control Program to deliver integrated anti-tobacco activities: raising public awareness about the dangerous health impacts of tobacco use and working to create a tobacco free community. The DOH Tobacco program sponsors periodic statewide and regional contractor meetings for DOH and LHJ staff and requires LHJ staff and/or stakeholder/volunteer attendance.

  The DOH program administers funds for the program, which are passed through to LHJs through the consolidated contract. DOH provides technical assistance and other supports to LHJs, community-based and school-based programs, conducts a statewide anti-tobacco media campaign, provides a 1-800 information and referral line for adults who are thinking of quitting smoking, and educates retailers to prevent tobacco sales to minors. Additionally, the program collects data to support ongoing evaluation of program effectiveness and monitors the status of tobacco use across the state. (http://www.doh.wa.gov/Tobacco/)

- **Breast and Cervical Health Program** – Washington State's Breast and Cervical Health Program (BCHP) provides free breast and cervical cancer screening and diagnostic services to women ages 40 to 64, whose income is at or below 200 percent of the Federal Poverty Level, and reimburses participating medical providers for these services. The program's mission is to

provide community education and services that reduce breast and cervical cancer incidence and death in Washington State.

Program services are available statewide and include screening, public education, professional education, quality assurance, tracking/surveillance, and evaluation of service delivery components. DOH provides technical assistance and support to local BCHP Prime Contractors who administer the program regionally. Five LHJs are Prime Contractors for their regions (Tacoma-Pierce, Yakima, Thurston, Seattle-King County, and Spokane), with the remaining three regions served by hospitals or medical clinics (http://www.doh.wa.gov/wbchp/locations.htm) Clinics, private physicians, hospitals, LHJs, laboratories, and radiology facilities provide services. Reimbursement for clinical services is at the Medicare rate and includes routine office visits, clinical breast exams, screening mammograms, pap tests and other authorized diagnostic procedures. Many LHJs and community-based organizations contract to provide outreach activities with public education and community involvement.

DOH administers BCHP and provides statewide coordination http://www.fhcrc.org/cipr/bchp/

- **Injury Prevention and Safety Program** –Preventing injuries and death among people of all ages is a public health priority. LHJs use various strategies for reducing death and disability in their communities due to injury: child passenger safety; drowning prevention; helmet safety; traffic safety; and suicide prevention. Community coalitions are often involved in efforts to prevent injuries and promote safer communities.

  At the State level, the DOH Injury Prevention and Safety Program provides funding, technical assistance, data and special reports to identify priority issues, and conducts activities aimed at reducing injuries http://www.doh.wa.gov/cfh/Injury/Default.htm.

Environmental Health Programs

Environmental health work applies science to the prevention of disease in humans from their environment, both natural and man-made. Environmental concerns of today often become the human health concerns of tomorrow. Therefore, environmental health work applies to prevention of potential disease and disease spread on both a short-term basis (e.g. food service establishment inspections to prevent foodborne illness) and on a long-term basis (e.g. groundwater monitoring around abandoned landfills to protect the water resource). Environmental health divisions within most LHJs carry out this work through regulatory controls, education, environmental assessment, monitoring of the environment, and surveillance of those factors that can lead to illness or disease. The legal authority for environmental health programs is based in a variety of federal and state laws, and rules and local ordinances.

Environmental Health programs in LHJs carry out mandates specified through statute as well as delegated responsibilities from other agencies at both the state and local levels. For example, LHJs contract with the Washington State Department of Ecology (Ecology) for authority for regulatory activities in the management and handling of solid wastes. In addition, some LHJs assume authority from Ecology to administer some components (sealing and decommissioning drinking water wells) of Chapter 173-160 WAC, *Well Construction and Maintenance.*

In several counties, as part of an on-going local government effort to streamline and make government more efficient, some or all environmental health programs have been moved into agencies other than the local health jurisdiction (most commonly a community development agency,

public works departments, or one-stop permit centers) However, this alignment may create management and communication problems and cloud the issue of the Health Officer's authority over the programs. Most importantly, though, the mission of Environmental Health to protect the public health is vulnerable to becoming lost in another non-public health agency's goals, such as an effort to improve 'permit turn-around' time.

Below is a description of environmental health programs most commonly found in LHJs.

- **Onsite Sewage Program** - The purpose of the onsite sewage program is the protection of the health of the people in the community from chemicals and disease causing organisms originating from the improper disposal of human sewage. The program focuses on the protection of ground and surface water from contamination and the prevention of human access to contaminants through proper handling and disposal of sewage. Local health officers are responsible for all onsite sewage systems that serve structures generating daily wastewater flows of 3,500 gallons or less at a common point. Because the program activities involve determining the size of a building lot and assessing the suitability of a building site for an onsite system, this program is politically sensitive in many local communities. A high degree of interaction with other county agencies is required. The Department of Licensing must certify inspectors who work in this program. Persons who design on-site sewage systems must also be licensed as designers by the Department of Licensing. Onsite sewage is a demanding program, especially during the normal construction season.

  Funding is generated primarily through permit fees, Department of Ecology educational grants, and local dollars. The primary State relationship is with the State Board of Health, which sets the overall state standards, and with the Department of Health (DOH), which provides technical assistance, oversight and training to LHJs as well as review and guidance on new and innovative systems and designs (www.doh.wa.gov/ehp/ts).

- **Drinking Water Program -** The purpose of the Drinking Water Program is to protect the health of communities by ensuring access to safe and reliable drinking water. Funding is primarily through plan review fees, local dollars, Department of Health pass-through funding, and Department of Ecology pass-through fees. The DOH Office of Drinking Water (www.doh.wa.gov/ehp/dw) has responsibility for overseeing a comprehensive program for all water systems that are subject to the federal Safe Drinking Water Act (SDWA) through Chapter 246-290 WAC.

  LHJs and local health officers have independent authority under RCW 43.20.050, 70.05 and through local/state agreements have delegated authorities under Chapters 246-290, 246-291, and 173-160 WAC to oversee the safety of drinking water and public water systems. Generally the water program works under a joint plan of operation (JPO) negotiated with DOH. Under the JPO, LHJs usually agree to regulate small public water systems defined as "Group B Water Supplies." JPOs are developed individually with each LHJ and therefore are different from jurisdiction to jurisdiction. Group B or state regulated drinking water systems are regulated under Chapter 246-291 WAC.

  Most LHJs also determine the availability of adequate water supply for new land development projects and individual building projects under the authority of the state Growth Management Act. In addition, LHJs provide a level of non-regulatory technical assistance to private well owners related to the protection of the water system from contamination. The level and types of technical assistance depends upon the resources and skill level of staff within the jurisdiction.

There are three regional DOH Drinking Water Offices providing direct services and technical support to LHJs. Those three offices are located in Spokane, Kent, and Olympia. The Spokane office services those LHJs on the east side of the state. The Kent office provides services to the northwest portion of the state. The Olympia office provides services to the southwest portion of the state.

- **Solid Waste Program -** The purpose of the solid waste program is to control the disposal of solid waste materials that may affect the health of the people in the community. These effects may include chemical contamination of the groundwater that serves as drinking water sources, control of explosive gases generated through the degradation of some solid wastes, and problems with rodents and other vectors associated with improperly managed wastes. The local health officer is delegated his/her authority by Chapter 70.95 RCW and Chapter 173-304 WAC to enforce regulatory requirements for the management and handling of solid wastes. The permitting and inspection of solid waste facilities and the investigation of unlicensed sites for compliance, usually resulting from solid waste complaints, are the primary tools of enforcement for the protection of public health and the environment. Fees for annually permitted facilities and a solid waste enforcement grant from Ecology fund the solid waste program. Ecology is the State agency responsible for solid waste disposal. WACs developed by Ecology have identified LHJs as the local enforcement arm.

- **Food Program -** The purpose of food programs is to prevent the spread of food borne disease in the community. Most environmental health programs conduct a food program to assure sanitary standards in food service operations to prevent disease and chemical exposure under WAC Chapter 246-215. Each permitted food service establishment must be inspected at least once per year, and establishments with a higher risk (termed complex menu facilities) are to be inspected at least twice per year. Education is a major component of the food program. The staff is expected to incorporate education in their routine inspections and distribute educational handouts during inspections. Educational presentations are offered to food establishments, schools, and community groups. Most LHJs respond to complaints of food-borne illness outbreaks and work with the LHJ personal health staff (and epidemiologists, where available) to conduct investigations of the outbreaks.

  One of the rapidly increasing segments of the program deals with temporary food facilities such as at fairs and community events. These events usually occur on weekends and require that food staff adjust their work schedules. In addition to the increasing workload from new permitted establishments there is an increase in food products coming from outside the United States that may not have the same sanitary standards found in the same products grown in this county. Also with the in-migration of new residents from around the world LHJs are facing new menus and methods of food preparation that are challenging to work with. DOH provides technical assistance, education and will provide program audits upon request of the local jurisdiction. (www.doh.wa.gov/ehp/)

  Food Worker Card Program: All food service workers in the state are required to demonstrate through the process of examination that they possess an adequate knowledge of the principles and practices involved in the safe preparation, storage and service of food. Revisions to Chapter 246-217 WAC, effective January of 2000 mandated LHJs to provide at least 30 minutes of instruction to food workers. The State Board of Health sets the fee for Food Workers Permit.

- **Schools***:* Chapter 246-366 WAC allows for health and safety inspections in schools as well as review of school construction plans, pre-occupancy inspections, response to complaints, and

consultation on a variety of issues, ranging from indoor air quality to playground equipment. Most LHJs do not routinely inspect schools due to funding restrictions. However, all LHJs inspect the food service operations in public schools and provide other technical assistance upon request*.*

- **Vector Control Program***:* Preventing the spread of disease from vectors to humans is also a public health responsibility. Most LHJs educate the public about the risks of animal/insect-carried diseases and respond to reported cases of human illness and exposure to illness caused by animals and insects including rabies, hantavirus, west Nile virus, mad cow disease, and tick-borne relapsing fever. LHJs are involved in the reduction of harborage for rodents, mosquitoes and a number of other insects and mammals that can transmit disease on to humans. Funding almost always comes from local tax dollars, as there is no practical way to charge fees for these activities. DOH staff provides technical assistance and training in these programs. www.doh.wa.gov/ehp/ehp/ts

- **Water Recreation (Chapter 246-260***)*: DOH is responsible for enforcement of water recreational facilities (swimming pools, spas, wading pools and spray pools). LHJs can assume authority if they negotiate and sign a Joint Plan of Operation (JPO) with DOH and accept responsibility. Currently all LHJs inspect and permit public swimming pools within their jurisdictions. In addition to conducting inspections, LHJs may respond to complaints, review construction plans, conduct per-occupancy inspections, and provide consultation/training to pool operators. The funding for the program comes from the fees for the permit to operate.

- **Clandestine Drug Laboratory (Chapter 246-205 WAC***):* DOH has responsibility to develop regulations for decontamination of illegal drug manufacturing or storage sites. DOH tests and licenses clean-up contractors and provides technical assistance to LHJs. LHJs are responsible for the posting of property found to be contaminated, inspection of that property to determine the level and amount of contamination, determining whether a contractor is required to clean the property, and verifying decontamination. Funding for this program is usually from local dollars or Ecology through one of the Model Toxic Control Accounts (MTCA).